

**Connecticut General Assembly
Insurance and Real Estate Committee
March 1, 2022**

Representative Wood, Senator Lesser, Representative Pavalock-D'Amato, Senator Hwang members of the Insurance and Real Estate Committee, my name is Carine Boustany and I am the Head of our U.S. Development site in Ridgefield and I am also the Global Head of Development Sciences at Boehringer Ingelheim.

On behalf of Boehringer Ingelheim (BI), I submit this testimony in **opposition to Governor's Bill 13**, An Act Reducing Prescription Drug Prices.

Boehringer Ingelheim is a family-owned, research driven pharmaceutical company with about 2,100 employees in the state of Connecticut and 52,000 employees globally. We are the largest headquartered pharmaceutical company in the state and established our headquarters in the towns of Danbury and Ridgefield in 1971. For more than 150 years, Boehringer Ingelheim (BI) has been committed to the research and development of innovative medicines that improve the lives of patients and their families.

Summary

This bill would impose government price controls by instituting a drug price cap of 2% plus CPI and also allow for drugs to be imported from Canada. BI strongly opposes both policies. A simple drug price cap oversimplifies an overly complex system, and the bottom line is it will have no impact on the price patients pay at the pharmacy counter. Importation from Canada means poking holes in our current closed pharmaceutical supply chain putting patients at risk. BI continues to stand ready to partner on real solutions that will help patients.

Price Cap Will Not Help Patients

First, let's be clear – patients are exhausted by the prescription drug pricing system in the U.S. I get it – I hear the frustration directly from my family and friends. And, BI shares this frustration – we want to ensure patients have access to the drugs we develop. However, the Governor's proposal does not achieve its objective – it simply will not change the price a patient pays at the pharmacy counter.

Governor Lamont's drug price cap proposal oversimplifies the realities of an extremely complicated healthcare payment model by focusing only on the costs of prescription drugs and

not addressing systemic inefficiencies. Specifically, the price set by a pharmaceutical company has little to do with the amount paid by a patient at the pharmacy counter which is typically controlled by the patients' health insurance plan through deductibles, co-pays and other cost sharing plan designs. Other stakeholders also impact costs in between manufacturer and pharmacy counter purchase such as pharmacy benefit managers (PBMs). This is not to start blaming others in the healthcare ecosystem but to highlight the reality of an overly complex pricing system that cannot be fixed with a single bill from a single state. For example, manufacturer pricing is impacted by pressure from PBMs to deliver higher and higher rebates. If manufacturers like BI do not provide increasing rebates, the result could mean our medicines are not offered to the patients the PBMs represent. Rebates, discounts, and fees manufacturers pay have more than doubled since 2012. But in 2019, net prices for brand medicines increased by just 1.7% in line with or below inflation for the fifth year in a row¹. Put into dollars: In 2013 payers such as insurers, PBMs and government programs received over \$50.13 billion in rebates, discounts and other payments to lower the cost of medicines. In 2020 that number increased to over \$140 billion.ⁱ We would prefer those rebates, discounts and other payments go to patients so they can afford their medicine.

This is why we urge policy makers to focus on net price versus list price (or, what the industry refers to as wholesale acquisition cost – WAC). New laws should include improving transparency around how rebates are used, imposing a fiduciary duty on PBMs, and ensuring rebates are passed through to patients.

Importation Is Dangerous and Not a Realistic Solution

The U.S. Food and Drug Administration (FDA) regulates and protects the U.S. supply chain but does not do so in foreign countries. Therefore, the FDA has repeatedly said that drug importation could jeopardize public health by allowing unsafe medicines into the U.S. via an already stretched system. Medicines that enter the United States through importation will not be subject to these same strong standards and, as a result, counterfeit, substandard or diverted, repackaged and adulterated drugs could be introduced into our secure drug supply chain.

Canadian authorities have expressly stated they are not responsible for the safety and quality of prescription drugs exported from Canada into the United States.

The resources required to ensure the safety and efficacy of any drugs being imported from or passing through other countries into the United States would outweigh any potential savings. A recent Wyoming study indicated savings would be minimal and probably even unsustainable². Furthermore, it's not clear whether savings would offset the costs of operating the program. For

¹ IQVIA. "Medicine Spending and Affordability in the U.S."

² Wyoming Dept. of Health, Memo to Joint Labor, Health, and Social Services Interim Committee and Joint Appropriations Committee. Legislative report: Prescription Drug Costs in Wyoming. Oct. 1, 2020.

example, Florida received no bids for a \$30 million contract to administer their importation program. Ultimately Florida contracted with a company for about \$39 million to work to implement the program. It is important to note that price does not include the purchase of drugs.

States pursuing importation realize inherent pitfalls. As of December 2021, several states have enacted legislation, but none have received federal approval. This is primarily due to safety concerns, lack of adequate savings, and the sheer challenge of supplying the U.S. market.

For those that point to individuals already successfully purchasing medicines from Canada it is important to note the current level of utilization is significantly lower than wholesale importation policy would deliver. Therefore, a wholesale importation program would have more significant consequences on the availability of medicines.

Hurt Innovation

The unintended consequences of these proposals are significant – including stifling innovation of future breakthrough therapies. BI reinvests over 20% of our net sales into research & development and this proposal would negatively impact those investments. We've all seen the value of research and development, as our industry peers in drug discovery quickly ramped up efforts and introduced new COVID-19 vaccines in record time. The research and discovery of first-in-class drugs is an expensive and time-consuming investment. The average drug takes about 10 years and costs about \$2.6 billion to develop. Policies like a price-cap means companies have to make decisions about what types of disease states we can invest our time and money. BI is also focused on areas of high unmet need and strive to develop first-in-class therapies. These are all areas of critical importance to our patients. It also leads me to an example of how this proposed bill would specifically impact patient populations with high unmet need. My team is pursuing research in schizophrenia – a population that is in particular need of new and better medicines. This population is also often facing social-economic challenges – incarceration rates are very high in this group and many face difficulties finding and holding onto jobs leading to a lower quality of life. These social-economic challenges results in many individuals with schizophrenia are in the Medicaid population. Medicaid has penny pricing – meaning we make pennies on medications sold through Medicaid or in some cases we actually pay Medicaid to sell our drug. In order to continue pursuing our research in schizophrenia we need to make the investment case. With penny pricing in Medicaid plus significant rebates and now a possible cap on the commercial market it forces us to direct investment to other areas leaving the populations that need treatment options the most – such as those with schizophrenia – without the help they need. This type of policy forces research out of these areas and these are the areas with the greatest need.

I cannot emphasize enough how proud I am of the work from my team at BI and our peers in other research groups around the world have continue to deliver. I am honored to take this opportunity to highlight the individuals who dedicate themselves to finding treatment and cures

for patients. Without the pharmaceutical companies' investment in technology, talent and time our state, country and world would be facing a very different future.

Conclusion

Boehringer Ingelheim is proud to call Connecticut home to our U.S. headquarters for the past 50 years. I have the privilege of working with highly skilled and dedicated professionals and we are supported by wonderful communities that many of us live in. Our company and its founding family have always been steeped in research and development and our dedicated teams stand ready to be a resource to policy makers.

We continue to welcome the opportunity to work with Governor Lamont and the legislature to identify solutions that benefit patients; however, the current proposals do not support this goal.

ⁱ From the Berkeley Research Group can be found at pharma.org/cost